

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

318

1003

5455 62-020540
STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

Primary Registration District No.

Registrar's No.

FILED JUN 7 1962

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN Bellefontaine Neighbors	
Length of stay in 1b 2 weeks		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Luke's Hospital		d. STREET ADDRESS (If outside, give location) 935 Chain of Rocks Drive	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Ralph Hummel		4. DATE OF DEATH Month Day Year May 30 1962	
5. SEX male	6. COLOR OR RACE white	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 8-6-1910
9. AGE (last birthday) 51		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		12. KIND OF BUSINESS OR INDUSTRY Lincoln Engineering	
13. BIRTHPLACE (City and state or country) Weir, Kansas		14. CITIZEN OF WHAT COUNTRY U.S.A.	
15. FATHER'S NAME Paul O'Niell		16. MOTHER'S MAIDEN NAME Lydia Daugherty	
17. NAME OF HUSBAND OR WIFE Luella Hummel		18. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes 2nd World War	
19. SOCIAL SECURITY NO.		20. INFORMANT Mrs. Luella Hummel, 935 Chain of Rocks Dr.	
21. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Brain tumor, verified, Glioblastoma, Rt. occipital lobe DUE TO (b) Lt. parietal lobe, Brain DUE TO (c) 193.0		INTERVAL BETWEEN ONSET AND DEATH 6 mos	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
22. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	23. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	24. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
25. TIME OF INJURY Hour a.m. p.m. Month, Day, Year		26. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
27. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		28. CITY, TOWN, OR LOCATION 1-4-62 to 5-30-62 and last saw him alive on 5-29-62	
29. I attended the deceased from 2:15 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.		30. SIGNATURE (Degree or title) George E. Rouhan M.D.	
31. ADDRESS 3720 Washington Ave. St. L.		32. DATE SIGNED 5-31-62	
33. BURIAL, CREMATION, REMOVAL (Specify) Removal	34. DATE June 2, 1962	35. NAME OF CEMETERY OR CREMATORY Park Lawn Cemetery	36. LOCATION (City, town, or county) (State) Barry, Illinois
37. FUNERAL DIRECTOR Math Hermann & Son, Inc., 2161 E. Fair Ave St. Louis 7, Missouri		38. DATE RECD. BY LOCAL REG. MAY 31 1962	
39. REGISTRAR'S SIGNATURE Gean Smith, M.D.		40. REGISTRAR'S SIGNATURE	

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK
OR
TYPEWRITER RIBBON

VS 300
Rev. 4/59

1

2 400138

3

4 0

5 1

6

7 1

8 2

9

10

11

12 81-0

13

81

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Julius R Brown

Licensed Embalmer No.

5146

P. O. Address

St Louis Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.